State Funded Community Supports

May 2015

Program Description

State Funded Community Supports (SFCS) is an array of services offered and funded by DDSN to those who are eligible for DDSN services but are not currently eligible for a DDSN-operated Home and Community Based Waiver.

Draft of
Revised Program Entrance Criteria

First Priority: Those awarded an ID/RD or Community Supports waiver slot on or after July 1, 2014 or HASCI waiver slot on or after October 1, 2013, but were not enrolled[1] or those who are dis-enrolled[2] from the ID/RD or Community Supports waiver after July 1, 2014 or HASCI waiver after October 1, 2013.

- [1]Inability to enroll is limited to those who are determined to not meet level of care criteria or those determined not eligible for Medicaid and does not include failure to apply for or complete the application/application process for Medicaid.
- [2]Dis-enrollment from the waiver is limited to those who fail to continue to meet level of care criteria.

Second Priority: Those who are not currently receiving any in-home supports (e.g., Community Choices Waiver, Rehabilitative Behavioral Health Services, etc.) whose situation has been determined to meet criteria for "Critical Needs" as defined in DDSN Directive 502-05-DD entitled DDSN Waiting Lists, but residential services are not anticipated to be provided for at least thirty (30) days (Critical)

Draft of
Revised Program Entrance Criteria

Third Priority: Those who are not currently receiving any in-home supports (e.g., Community Choices Waiver, Rehabilitative Behavioral Health Services, etc.) for whom the provision of services offered through the State Funded Community Supports program will address needs which, if not provided, will likely result in the person's situation being deemed a "Critical Need" in accordance with DDSN policy. (Divert Critical)

Forth Priority: Those who are not currently receiving any in-home supports (e.g., Community Choices Waiver, Rehabilitative Behavioral Health Services, etc.) who live with a primary caregiver who is eighty (80) years of age or older. (Elderly Caregiver)

SFCS - Cost Limit

The annual cost limit for State Fiscal Year 2015 is **$12,624.00**

- Participants may receive service(s) that cost no more than the annual cost limit per state fiscal year (July 1- June 30).
- The annual cost limit will be prorated for those who begin participating during any month other than July. Funding not used during the state fiscal year cannot be carried forward to the next year.
- The annual cost limit is subject to change each State Fiscal Year.

Case Management

State Funded Community Supports participants will be eligible for and will receive Case Management.

- If not receiving or not eligible for Medicaid Targeted Case Management, State Funded Case Management will be approved;
- If receiving Medicaid Targeted Case Management (MTCM) from a DDSN-contracted provider, it can continue.

Funding for Case Management will be provided in addition to the funding available for participant services (annual cost limit).

Financial Management

State Funded Community Supports participants will be assigned to a Financial Management Agency (FMA) who will:

- pay authorized providers for rendering of authorized services;
- reimburse participants/others for the purchase of authorized products;
- purchase and arrange for the delivery of authorized products.

Funding for Financial Management will be provided <u>in addition to</u> the funding for:

Case Management and

participant services (annual cost limit).

Case Manager Responsibilities

- Explain the program and enroll the participant.
- Complete a new or update an existing Case Management Assessment and Plan (CMAP).
- Develop a budget for the services to be provided.
- Implement the plan.

STATE FUNDED COMMUNITY SUPPORTS
BUDGET CALCULATOR - FY 15

PARTICIPANT NAME: _____

SSN: _____

ENROLLMENT DATE: 02/14/15 (MM/DD/YY)

ANNUALIZED FUNDING **$ 12,624.00**

AVAILABLE FUNDING - FY 15 **$ 5,260.00**

AMOUNT BUDGETED BELOW **$ (5,162.05)**

BALANCE REMAINING **$ 97.95**

AVAILABLE SERVICES

	Budgeted Units	Note	Unit Cost	Per	Total Cost
DAY SUPPORTS					
Employment Services - Inividual	45	based on assessment	$ 67.29	Hour	$ 3,028.05
Employment Services - Group			$ 22.00	Half day	$ -
Career Preparation	40	4 weeks	$ 22.00	Half day	$ 880.00
Community Services			$ 22.00	Half day	$ -
Day Activity			$ 22.00	Half day	$ -
Support Center			$ 22.00	Half day	$ -
Adult Day Health			$ 45.00	Day	$ -
Adult Day Health - Transportation			$ 7.50	One Way	$ -
Adult Day Health - Nurisng			$ 15.00	Day	$ -
OTHER SERVICES					
Personal care I	288	4 hrs/wk for 18 weeks	$ 3.00	15 minutes	$ 864.00
Personal care II			$ 4.00	15 minutes	$ -
Respite and In Home Supports					
(maximum $300 per month)				Manual Price	$ -
Incontinence Supplies				Manual Price	$ -
Assistive Technology				Manual Price	$ -
Enviormnetal Modification				Manual Price	$ -
Private Vehicle Modification				Manual Price	$ -
Personal Emerg. Response - Install	1		$ 30.00	Item	$ 30.00
Personal Emerg. Repsonse - Recurring	12		$ 30.00	Month	$ 360.00
Behavior Supports			$ 30.00	Hour	$ -

Total Budgeted Cost **$ 5,162.05**

The completed Budget (and any updates) must be provided to the Financial Management Agency by the Case Manager.

Implementing the Plan
Arranging and Authorizing /Requesting

Once SFCS services are assessed, planned and budgeted, the Case Manager will arrange for and authorize/request the services.

Authorizations/Requests

- All State Funded Community Support services must be authorized via a written authorization which is completed by the Case Manager.

- There is a unique/specific form(s) to be used to for each service.

- Written instructions for the forms are included in the State Funded Community Supports Manual.

A copy of **all** Authorization / Request forms issued for a participant must be sent to the Financial Management Agency and are to be sent at the time of issuance.

Payment for all delivered State Funded Community Supports services will be made by the participant's Financial Management Agency.

Please Note: *This may be a new or unique situation for some service providers and may require explanation. The Financial Management Agency's representative should be prepared to answer providers' questions about billing, payment, etc. of SFCS services.*

Implementing the Plan
Arranging and Authorizing /Requesting

For State Funded Community Supports the total service package is divided into:

Services (*a service is being delivered*) which are Personal Care, Adult Day Health, etc.

Products *(an item/product is being delivered)* Incontinence Supplies, Assistive Technology & Appliances, etc.)

Implementing the Plan
Arranging and Authorizing /Requesting

Services

(e.g., ADHC, PC 2, Emp.)

will be authorized/requested differently than

Products

(e.g., Inc. Supplies, Asst. Tech)

Arranging and Authorizing Services

When a *service* (e.g., Personal Care, Adult Day Health, etc.) is to be delivered, the Case Manger will:

- offer the participant or his/her representative a choice among available providers of the service (*See SCDDSN's web site: http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx for the list of qualified providers);*
- document the offering of choice in the service notes;
- authorize / request the service to/from the chosen provider *;*
- update the Service Tracking System (STS) "Services Menu", if the *service* is DDSN Employment or Day Service (i.e., Adult Activity, Career Preparation, Community Supports, and Support Center).

Authorization / Request for Adult Day Health Care

TO: _____
(Adult Day Health Care Services Provider)

Re: **Name:** _____

Address: _____

_____

Date of Birth: _____

Beginning on the date noted below, you are hereby authorized to provide the following to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Adult Day Health Care Services

Number of Units per Week: _____ **[one unit = 1 (4 hour) day]**

The person noted above participates in SCDDSN's State Funded Community Supports program. Through this program, when authorized services are provided, payment for services, up to the amount authorized above, will be made by the Financial Management Agency serving the participant. For the person noted above, please request payment from and direct questions regarding payment to:

Financial Management Agency Name: _____

Address: _____

_____

Representative: _____
Name of Person to Contact

_____ _____
(Phone Number) *(Email address)*

Case Management Agency Name: _____

Case Manager's Name: _____

Case Manager's Contact Information: _____ _____
(Phone Number) *(Email address)*

_____ _____
Signature of Case Manager Authorizing Services **Date**

Respite and Home Support

This service is solely participant/representative managed. That means the participant/ representative:

- recruits
- determines wages and hires,
- trains,
- supervises, and
- pays

the worker (s).

Respite and Home Support

The Case Manager must:

- Assure the participant / representative understands his/her responsibility for managing the worker(s).
- Have a sense of how and when services will be provided
- Authorize a monthly amount to be paid to the participant / representative each month*
- Provide instructions to the participant/representative from the Financial Management Agency specifying the documents to be submitted, to whom and when that verify the monthly amount paid was spent for services provided.

**Case Manager can approve up to $300.00 per month, amounts in excess of $300.00 will require District Office approval.*

Respite and Home Support

The Financial Management Agency must provide the Case Manager with the FMA's specific written instructions for what documentation is required to verify that money provided for the service was spent

These instructions will be given to the participant/representative who is managing the service by the Case Manager.

Instructions Should…

Include:

- **The specific types of documentation that will be considered acceptable** (e.g., timesheets signed by the worker) **or required forms,** and
- **The statement of expected timelines for submission**

NOTE: Completed samples or examples are encouraged

Authorizing /Requesting

Services

(e.g., ADHC, PC 2, Emp.)

will be authorized/requested differently than

Products

(e.g., Inc. Supplies, Asst. Tech)

Authorizing/Requesting Products

When a ***product*** (e.g., Incontinence Supplies, Assistive Technology & Appliances, etc.) is to be delivered, the participant or his/her representative will choose the method through which the products will be secured, either:

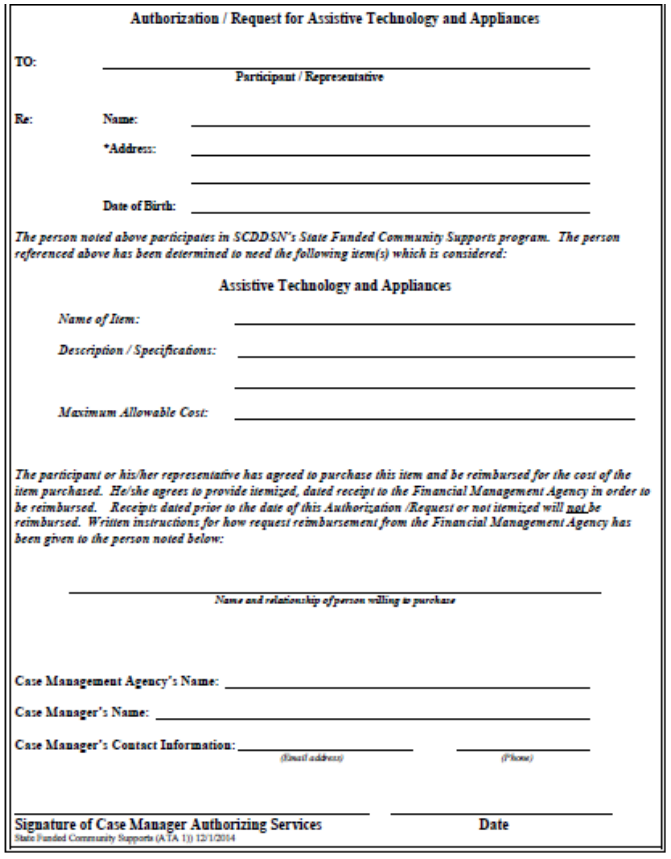
Reimbursement

or

Financial Management Agency Purchase

Two different forms to Authorize/Request Product(s)

Reimbursement



Authorization / Request for Assistive Technology and Appliances

TO: _____
Participant / Representative

Re: Name: _____
*Address: _____
_____
Date of Birth: _____

The person noted above participates in SCDDSN's State Funded Community Supports program. The person referenced above has been determined to need the following item(s) which is considered:

Assistive Technology and Appliances

Name of Item: _____
Description / Specifications: _____
_____
Maximum Allowable Cost: _____

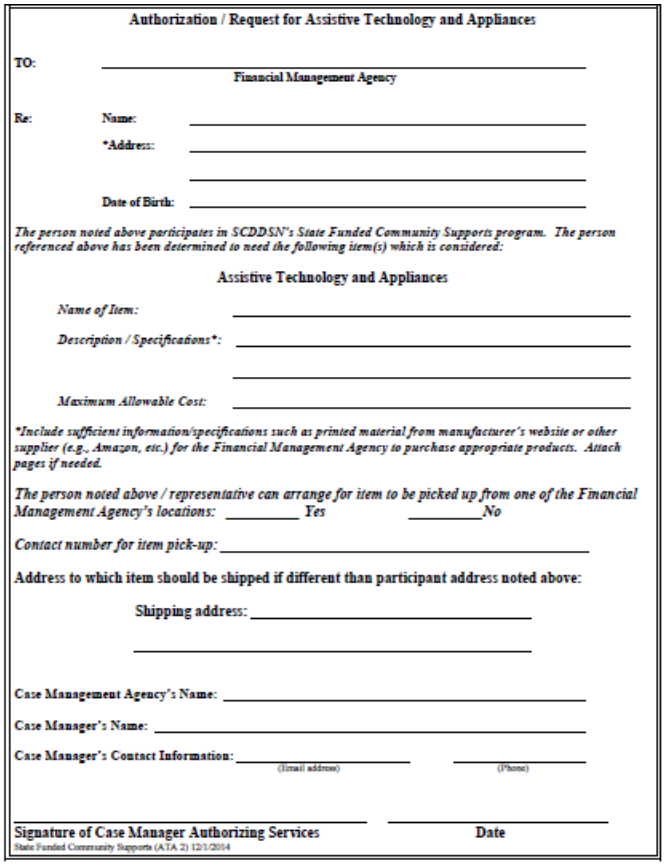
The participant or his/her representative has agreed to purchase this item and be reimbursed for the cost of the item purchased. He/she agrees to provide itemized, dated receipt to the Financial Management Agency in order to be reimbursed. Receipts dated prior to the date of this Authorization /Request or not itemized will not be reimbursed. Written instructions for how request reimbursement from the Financial Management Agency has been given to the person noted below:

_____
Name and relationship of person willing to purchase

Case Management Agency's Name: _____
Case Manager's Name: _____
Case Manager's Contact Information: _____ _____
(Email address) (Phone)

_____ _____
Signature of Case Manager Authorizing Services Date
State Funded Community Supports (ATA 1)) 12/1/2014

FMA Purchase



Authorization / Request for Assistive Technology and Appliances

TO: _____
Financial Management Agency

Re: Name: _____
*Address: _____
_____
Date of Birth: _____

The person noted above participates in SCDDSN's State Funded Community Supports program. The person referenced above has been determined to need the following item(s) which is considered:

Assistive Technology and Appliances

Name of Item: _____
Description / Specifications:* _____
_____
Maximum Allowable Cost: _____

**Include sufficient information/specifications such as printed material from manufacturer's website or other supplier (e.g., Amazon, etc.) for the Financial Management Agency to purchase appropriate products. Attach pages if needed.*

The person noted above / representative can arrange for item to be picked up from one of the Financial Management Agency's locations: _____ *Yes* _____*No*

Contact number for item pick-up: _____

Address to which item should be shipped if different than participant address noted above:

Shipping address: _____
_____

Case Management Agency's Name: _____
Case Manager's Name: _____
Case Manager's Contact Information: _____ _____
(Email address) (Phone)

_____ _____
Signature of Case Manager Authorizing Services Date
State Funded Community Supports (ATA 2) 12/1/2014

Arranging and Authorizing/Requesting Products using the Reimbursement Method

The **Reimbursement** will be offered first.

The **Reimbursement** method can be used **if** the participant/representative is:

- willing and able to purchase the needed item,
- willing and able to wait for reimbursement, and
- willing and able to follow the specific instructions from the Financial Management Agency (FMA) in order to be reimbursed.

Instructions for Reimbursement Required

The Financial Management Agency must provide the Case Manager with the FMA's specific written instructions for how reimbursement for items purchased is to be sought.

These instructions will be given to the participant/representative who is agreeing to make the purchase by the Case Manager.

As previously stated…

When a ***product*** (e.g., Incontinence Supplies, Assistive Technology & Appliances, etc.) is to be delivered, the participant or his/her representative will choose the method through which the products will be secured, either:

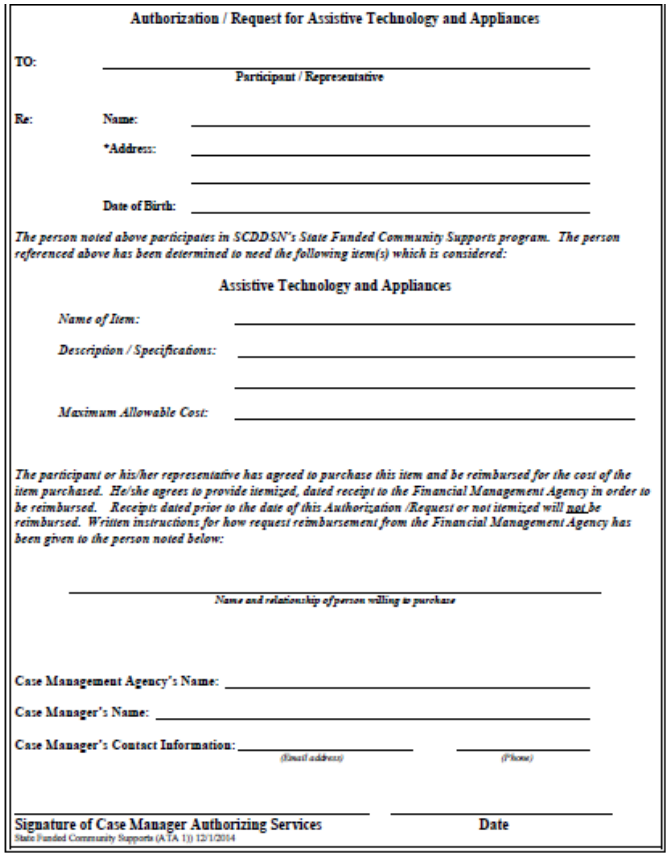
Reimbursement

or

Financial Management Agency Purchase

As previously stated…
Two different forms to Authorize/Request Product(s)

Reimbursement



Authorization / Request for Assistive Technology and Appliances

TO: _____
Participant / Representative

Re: Name: _____
*Address: _____
_____
Date of Birth: _____

The person noted above participates in SCDDSN's State Funded Community Supports program. The person referenced above has been determined to need the following item(s) which is considered:

Assistive Technology and Appliances

Name of Item: _____
Description / Specifications: _____
_____
Maximum Allowable Cost: _____

The participant or his/her representative has agreed to purchase this item and be reimbursed for the cost of the item purchased. He/she agrees to provide itemized, dated receipt to the Financial Management Agency in order to be reimbursed. Receipts dated prior to the date of this Authorization /Request or not itemized will not be reimbursed. Written instructions for how request reimbursement from the Financial Management Agency has been given to the person noted below:

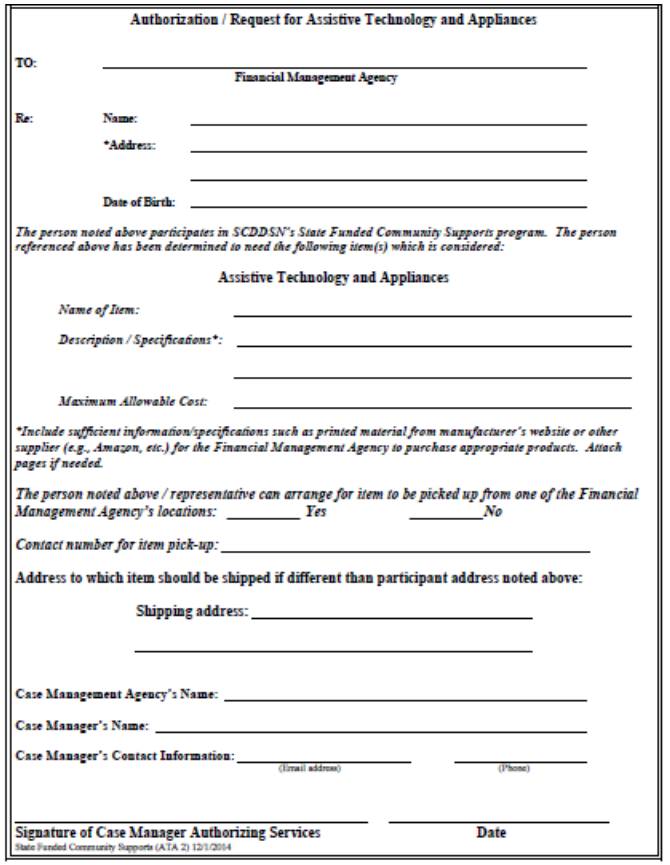
_____
Name and relationship of person willing to purchase

Case Management Agency's Name: _____
Case Manager's Name: _____
Case Manager's Contact Information: _____ _____
(Email address) (Phone)

_____ _____
Signature of Case Manager Authorizing Services Date

State Funded Community Supports (ATA 1)) 12/1/2014

FMA Purchase



Authorization / Request for Assistive Technology and Appliances

TO: _____
Financial Management Agency

Re: Name: _____
*Address: _____
_____
Date of Birth: _____

The person noted above participates in SCDDSN's State Funded Community Supports program. The person referenced above has been determined to need the following item(s) which is considered:

Assistive Technology and Appliances

Name of Item: _____
Description / Specifications:* _____
_____
Maximum Allowable Cost: _____

**Include sufficient information/specifications such as printed material from manufacturer's website or other supplier (e.g., Amazon, etc.) for the Financial Management Agency to purchase appropriate products. Attach pages if needed.*

The person noted above / representative can arrange for item to be picked up from one of the Financial Management Agency's locations: _____ *Yes* _____*No*

Contact number for item pick-up: _____

Address to which item should be shipped if different than participant address noted above:

Shipping address: _____
_____

Case Management Agency's Name: _____
Case Manager's Name: _____
Case Manager's Contact Information: _____ _____
(Email address) (Phone)

_____ _____
Signature of Case Manager Authorizing Services Date

State Funded Community Supports (ATA 2) 12/1/2014

Financial Management Agency Purchase method can be used if the participant / representative is not willing or able to be reimbursed for the product.

Reimbursement will be offered first.

Financial Management Agency Purchase

"Financial Management Agency Purchase" means the FMA buys the product for the participant from any retailer and arranges for delivery of the product to the participant.

"Any retailer" = local store or on-line store chosen by the FMA.

Financial Management Agency Purchase

When the "**Financial Management Agency Purchase**" is used the Case Manager must provide the :

- Specifications of the item/product (*e.g., brand and size of diapers; dimensions of microwave oven, etc.),* and
- Specific delivery information

Financial Management Agency Responsibilities Environmental Modifications

When needed, the Case Manager will provide the FMA with an Authorization / Request for Environmental Modifications which includes:

- the specifications /scope of the work to be completed, and
- the maximum allowable cost

The FMA must work with the Case Manager and the homeowner to find a contractor.

State Procurement policy must be followed.

Financial Management Agency Responsibilities
Private Vehicle Modifications

When needed, the Case Manager will provide the FMA with an Authorization / Request for Private Vehicle Modifications which includes:

- the specifications /scope of the work to be completed, and
- the maximum allowable cost

The FMA must work with the Case Manager and the vehicle owner to find a contractor.

State Procurement policy must be followed.

Plan changes

An Authorization/Request for a service remains in effect until:

- A new authorization /request is issued
- A Notice of Reduction or Termination is issued.

The Financial Management Agency must be informed of the changes.

Notice of Reduction or Termination

A **Notice of Reduction or Termination** form is used to notify the participant/representative and/or the service provider and the Financial Management Agency of the action.

Disenrollment

Participation in this program will end if / when the participant:

- Enrolls in a DDSN –operated Medicaid Home and Community Based Waiver;
- Is admitted to an ICF/IID or Nursing Facility;
- Voluntarily withdraws or no longer wishes to receive State Funded Community Supports;
- Moves out of state, into a PRTF or a Correctional Facility;
- Is admitted to a DDSN-sponsored Residential setting (e.g., CTH, CRCF, SLP)
- Refuses to cooperate with the terms listed in the Statement of Understandings, Rights, and Responsibilities.

When the person's participation in the program cannot continue, the **State Funded Community Supports – Notice of Disenrollment** form must be completed and the effective date of the disenrollment noted. The completed form must be sent to the participant / representative, the Financial Management Agency and to DDSN.

Forms to be Provided to the Financial Management Agency by the Case Manager

- **Budget (initial and with every change)**
- **Authorization /Request forms (for every service – when issued)**
- **Notice of Termination or Reduction forms (every form – when issued)**
- **Notice of Disenrollment (when issued)**

Information to be Provided to
the Case Manager
by the Financial Management Agency

1. **The Financial Management Agency's:**
    1. Name – the business name
    2. Address - the address to which a provider will send a bill for services rendered
    3. Representative's name - the person to be contacted by the provider who will answer questions about billing and payment for services
    4. Phone number for the Representative – the number a provider can call with questions
    5. Email address for the Representative – where providers can send email inquiries
2. **Written instructions for submitting verification that Respite & Home Support funds were spent.**
3. **Written instructions and forms, if applicable, for how to request reimbursement for purchased authorized products.**

For More Information

Please review the State Funded Community Supports manual which can be located DDSN's web site under "Service Providers" > "Manuals and Guidelines"

http://ddsn.sc.gov/providers/manualsandguidelines/Documents/State%20Funded%20Community%20Supports%20(030615).pdf